ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that **Precise Family Eyecare, P.C.** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me **Precise Family Eyecare, P.C.**'s Notice of Privacy Practice and agree to continue my care with **Precise Family Eyecare, P.C.** under said terms.
- ☐ I was given the opportunity to read **Precise Family Eyecare, P.C.**'s Notice of Privacy Practices and declined but wish to continue my care with **Precise Family Eyecare, P.C.** under the terms of **Precise Family Eyecare, P.C.**'s privacy policies.
- ☐ I have read or had explained to me **Precise Family Eyecare, P.C.**'s Notice of Privacy Practice and do not wish to continue my care with **Precise Family Eyecare, P.C.** under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient